George E. Wahlen
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
Veterans Affairs Salt Lake City Health Care System
500 Foothill Drive
Salt Lake City, UT 84148

Pharmacy Practice Residency Program Application

Applicant: _____
First Name *MI* *Last Name*

Present Address: _____
Street Address or P.O. Box

_____ ( )
City *State* *Zip Code* *Phone*

Permanent Address: _____
Street Address or P.O. Box

_____ ( )
City *State* *Zip Code* *Phone*

The following items must be received not later than January 1st to complete the application:

- ❑ Completed Application Form
- ❑ A current *Curriculum Vitae*
- ❑ Copies of official transcripts from all colleges of pharmacy attended
- ❑ Three (3) letters of recommendation completed on the Recommendation Request form (attached) from professional practioner or clinical faculty and mailed confidentially

INTERVIEWING: Interviews will be scheduled for late January through early February. The VASLCHCS utilizes Performance Based Interviewing. For more information: http://www.va.gov/pbi/

Please answer the following questions in the space provided below (typed or printed):

What are your professional goals and how will this residency help you achieve your professional goals?

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Describe a past achievement / accomplishment and explain how the skills used then will help you during your residency.

Describe 2 or 3 of your strengths and 2 or 3 of your weaknesses.

What do you do for fun or relaxation?

Applicant Signature_____**Date**_____

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Pharmacy Practice Residency Program Recommendation Request Form

To be completed by the applicant:

_____
First Name *MI* *Last Name*

_____
Street Address or P.O. Box

_____ (____)
City *State* *Zip Code* *Phone*

I waive the right to review this recommendation._____
Applicant Signature *Date*

Recommender to complete the following:

Applicants to the residency program specified above are required to have recommendations submitted by persons who are in a position to evaluate their qualifications for residency training. The recommender is asked to make a frank appraisal of the applicant's character, personality, abilities, and suitability for a pharmacy residency. **All comments and information provided will be kept in strictest confidence**. Thank you for your time and attention!

I have know the above applicant for approximately_____ years / _____months

My relationship to the above applicant was (or is) in the following capacity:

- ❑ Pharmacy manager at place of employment
- ❑ Clerkship preceptor
- ❑ Faculty advisor
- ❑ Other faculty relationship
- ❑ Other:_____

I have known the above applicant (please mark X on line):

- ❑ Very well
- ❑ Fairly well
- ❑ Casually

Does the applicant possess any special assets, which should be noted?

Does the applicant demonstrate any weakness which you believe might hinder his/her ability to perform effectively in a residency program?

Recommendation Request Form is TWO (2) Pages. Please complete second page.

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Relative to persons of similar background / training, please rate the applicant according to the following characteristics by placing an "X" in the appropriate box:

Characteristic	Upper 10%	Upper 25%	Upper 50%	Lower 50%	No Basis
Academic ability					
Quality of work					
Written communication skills					
Leadership skills					
Oral communication skills					
Industriousness / perseverance					
Initiative / motivation					
Assertiveness					
Cooperativeness					
Time management skills					
Ability to work with peers					
Ability to work with patients					
Dependability					
Resourcefulness / originality					
Acceptance of constructive criticism					
Appearance / professional demeanor					
Commitment to professional practice					
Emotional stability / maturity					
Enthusiasm					
Integrity					
Research skills					

Overall recommendation concerning applicant for residency program (please check one):

- ❑ I enthusiastically recommend this applicant without reservation.
- ❑ I recommend this applicant without reservation.
- ❑ I recommend this applicant, but with some reservation.
- ❑ I am not able to recommend this applicant.

Signature of Recommender_____ **Date**_____

Please provide the following information by completing this form or attaching a business card:

_____
Printed Name *Title / Affiliation*

_____ ( )
Street Address *City* *State* *Zip* *Telephone*

_____
Email Address

Please complete and return this form by January 1st to:

Carrie DeKorte, PharmD, BCPS
George E. Wahlen DVAMC
Pharmacy Services (119)
500 Foothill Drive
Salt Lake City, UT 84148

George E. Wahlen
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